CSHS AUTHORIZATION TO DISCLOSE INFORMATION

ND DEPARTMENT OF HUMAN SERVICES
CHILDREN'S SPECIAL HEALTH SERVICES (CSHS)
SFN 716 (03-2005)

Clear Fields

INSTRUCTIONS: Please Complete All Sections. Please Print.

Name of Client: (Last, First, Middle Initial)	Social Security Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code:

CLIENT AUTHORIZATION AND SIGNATURE

1. **I Hereby Authorize:**

Name of Person/Organization: **Children's Special Health Services**			
Street Address: **600 East Boulevard Avenue, Dept. 325**	City: **Bismarck**	State: **ND**	Zip Code: **58505-0269**
Name of Person/Organization:			
Street Address:	City:	State:	Zip Code:

2. **To Disclose Information To and Exchange Information With People or Organizations Identified Below:**

Primary Care Physician/Medical Home:			
Street Address:	City:	State:	Zip Code:
Medical Specialist/Clinic Team:			
Street Address:	City:	State:	Zip Code:
County Social Service Board:			
Street Address:	City:	State:	Zip Code:
Dentist:			
Street Address:	City:	State:	Zip Code:
Orthodontist:			
Street Address:	City:	State:	Zip Code:
Speech/Language Pathologist:			
Street Address:	City:	State:	Zip Code:
School/Special Education Unit:			
Street Address:	City:	State:	Zip Code:
Public Health Department:			
Street Address:	City:	State:	Zip Code:
Regional Human Service Center:			
Street Address:	City:	State:	Zip Code:

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

2. **To Disclose Information To and Exchange Information With People or Organizations Identified Below:**

Name of Person/Organization:			
Street Address:	City:	State:	Zip Code:
Name of Person/Organization:			
Street Address:	City:	State:	Zip Code:
Name of Person/Organization:			
Street Address:	City:	State:	Zip Code:

3. The Following Information May Be Requested or Exchanged:

Information determined necessary for prompt and accurate diagnosis, treatment and follow-up care including, but not limited to, team reports, office notes, progress reports, hospital discharge summaries, lab and x-ray results or other diagnostic studies.

4. The Information Identified Above Will Be Used For The Following:

Eligibility Determination **Treatment Planning**
Claims Payment **Care Coordination/Follow-up Activities**

5. This Authorization to Disclose Information Remains in Effect Until: (Date)

OR: (Specific Event Terminating Operation of the Release) **Until Revoked in Writing**

6. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form, including oral, written, or electronic transmission.

CLIENT AUTHORIZATION:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original.

Signature of Client (if 18 years old or older):		Date:
Signature of Parent/Guardian or Custodian (if needed):	Relationship:	Date:
Signature of Witness (if needed):		Date:

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification; failure to disclose this information will not affect the disclosure of information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

DISTRIBUTION:
- ☐ To agency/person from whom information is sought
- ☐ Requesting Agency
- ☐ Client
- ☐ Other _____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE